REPRESENTATIVE CHUCK BENEDICT
45TH ASSEMBLY DISTRICT

STATE CAPITOL
P.O. BOX 8952
MADISON, WI 53708

(608) 266-9967
TOLL-FREE: 1-888-534-0045
FAX: (608) 282-3645
E-MAIL: REP.BENEDICT@LEGIS.WI.GOV

ASSEMBLY COMMITTEE ON HEALTH

TESTIMONY IN SUPPORT OF ASSEMBLY BILL 71
BY REP. CHUCK BENEDICT
TUESDAY, NOVEMBER 20, 2007

Chairperson Vukmir and members of the committee, thank you for holding this hearing this morning on Assembly Bill 71. This bill is a redraft of last session's Assembly Bill 773 that was unanimously approved by this committee in March 2006.

Ms. Pam Charles, my constituent from Beloit, whose experience is the genesis for this legislation is unable to attend the hearing this morning, but her comments in support of AB 71 were emailed to your offices yesterday.

AB 71 is legislation that would require a health care facility, physician or employee of a health care facility to notify a patient – before visiting the physician's office – if a "facility fee" will be assessed for the services.

Per Ms. Charles' experience, she visited a physician for an opinion on a health care matter. Later, she received a bill that noted "Doctors Visit". She paid this bill. She then received a second bill from the same physician that was for the actual doctor's consultation. When she contacted the physician's office, she was informed that the first bill was for a "facility fee" – basically the physician was passing along the rent to her.

The intent of the bill is to require that patients be informed of a "facility fee" charge before they arrive to see the doctor so that they can make an informed decision if they choose to see that physician.

Perhaps you read this morning's lead story in the Wisconsin State Journal on how confusing health care billing is for the individual consumer. AB71 will provide an additional layer of transparency for the health care consumer in the mind-boggling world of health care billing.

Thank you for hearing this bill today. I would be happy to answer any questions you may have at this time.

From: Pam Charles
Sent: Monday, November 19, 2007 12:35 PM
To: Rep.Benedict
Subject: Re: Assembly Bill 71

Chuck,
I am sorry that I won't be able to come to Madison to testify Tuesday, but I am attending the funeral of a friend. I am happy to write a brief summary of my experience with Meriter Hospital and UW physicians that prompted my discussion with you regarding the need for this bill. Thank you for reading my testimony to the committee on my behalf.

In May of 2004, I visited a UW Health surgeon for a consultation. The surgeon's office was located in a clinic owned by Meriter Hospital. I was charged $266.00 for the doctor visit which was billed directly to my insurance company. At the same time, my insurance company received a bill from Meriter Hospital for what they said was a doctor visit in the amount of $157.00. My insurance company told me that they basically received two doctor bills for one doctor visit. I called Meriter Hospital and asked why they billed me $157.00 and they said it was a fee for allowing the UW physician to use their office, staff, billing system, etc. They called it a "facility fee" but they billed it to my insurance company as an outpatient doctor visit.

On July I went back to Madison to see another UW surgeon for a second opinion. That surgeon was located in the building next door to Meriter. I was in his office for the same length of time, he provided the same consultation, and his bill was for $216.00. That's $50.00 less than the first doctor's bill or $207.00 less than the first doctor's bill if you include the additional "facility fee."

I told Meriter that the facility fee seemed unfair and appeared to be a duplicate billing of services for the following reasons:

1. I had no knowledge that I was in a Meriter facility at all since I had made my appointment through UW Hospital and was given the physician's address without any explanation that I would be going to Meriter Hospital to see the physician.

2. I was never told, by anyone, that I would be charged a facility fee by Meriter.

3. When a physician sets a fee, it is supposed to cover the physician's expenses, such as office, staff, malpractice insurance, billing, etc. If the physician's fee does not include these expenses and the patient is expected to pay for these separately as a "facility fee" then the patient should be billed that much less by the physician.

So, in summary, I saw two UW Health physicians. One of those physicians pays his overhead out of his billings, like most doctors do. With the other doctor, the patient is billed an extra $157.00 to pay the physician's overhead, but the physician's bill is not $157.00 less. So essentially, the fees for the overhead are being billed twice to the patient.

Both physicians were of the same specialty; both were UW employees; both provided the same service; one cost a total of $423.00 and the other only $216.00. If UW is going to use Meriter offices, they should pay Meriter out of their physician's billings. The patient should not be expected to pay twice for a doctor's overhead.

I hope this explains the need for AB 71.

Thank you,
Pam Charles, RN
Beloit, WI

Complicated billing makes it hard to shop for health-care

DAVID WAHLBERG
608-252-6125
November 19, 2007

Heather Foxman was trying to be the health-care bargain shopper backers of increasingly popular consumer-driven insurance plans say Americans should become.

The pregnant woman, who has a high-deductible health plan, wanted to know how much she would pay for an ultrasound.

After being tossed between clinical and billing departments at Meriter Hospital, St. Mary's Hospital and Dean Health System, she got three similar quotes.

She went to Dean, the lowest bidder at $510. Then the bill came — for $942.

Foxman is among many pioneers in the consumer-driven health movement who are bumping up against a complicated billing system that has just started trying to become more transparent.

"Why can't you get a written estimate like you do from a car mechanic or somebody working on your home?" asked Foxman, 35. "We'd like to be empowered as health-care consumers, but it seems like we can't be."

About 5 percent of insured workers have high-deductible plans, usually paired with health savings accounts. The plans, which have become available in the past few years, generally have low premiums but have deductibles of about $1,500 for single coverage and about $3,000 for families. They encourage people to shop around by requiring them to pay full price for many bills out of their pockets or from the savings account.

The number of people with the plans is growing, surveys show, and the 5 percent figure doesn't include self-employed people such as Foxman. More employers are offering such plans — during open enrollment, which at most work places happens this time of year.

Meanwhile, employees in traditional health plans are paying higher premiums and co-pays, also leading people to think more about cost.

But hospitals and doctors' offices, accustomed to insurers' arcane billing

codes and negotiated discounts, are often caught off guard by patients who ask about price.

"We haven't been well equipped to deal with it because we haven't had to," said George Quinn, a senior vice president at the Wisconsin Hospital Association. "Now there's a need."

Tipping point?

A report last month by the hospital association's new task force on price transparency recommends that hospitals provide written estimates of price ranges for procedures.

But estimates included in the report from the Bay Area Medical Center in Marinette — which Quinn said is "out in the forefront on this" — show that price ranges can be very broad.

An X-ray of the ribs at the hospital costs $312 to $545. A CT scan of the spine: $998 to $1,725. An arthroscopic knee surgery: $3,571 to $15,145.

Consumers must check if physician fees are included in such estimates and if the prices factor in insurer discounts, which can be 30 percent or more.

"For most hospitals, there is no single source of information about price, as counterintuitive as that may sound," said Chris Queram, chief executive officer of the Madison-based Wisconsin Collaborative for Healthcare Quality. The organization, made up of hospitals, doctors and health plans, tracks the effectiveness of health care.

It's not clear how quickly the medical system will become more transparent about price, Queram said.

About 10 percent of American companies offered high-deductible health plans this year, up from 7 percent last year, according to the Kaiser Family Foundation. About 5 percent of workers enrolled in the plans, Kaiser's annual survey found, up from 4 percent last year.

"We haven't seen enough of the large employer market move in this direction to get to the tipping point," Queram said.

Cheryl DeMars, chief executive officer of the Employer Health Care Alliance Cooperative, a Madison-based group of 160 companies that collectively purchase health care, said consumers should keep asking for prices.

"The more people call, the more it will made available," DeMars said. "I'm a big believer in daylight being a good disinfectant."

Not everyone is sold on consumer-driven health plans, which have been shown, according to some reports, to reduce costly emergency room

visits and other health-care costs.

"The whole movement is being used by employers to offload more cost to the patient," said Dr. Richard Roberts, a family medicine professor at UW-Madison.

Roberts said high-deductible plans won't do much to reduce the vast majority of the nation's health-care expenses, incurred by relatively small groups of people with serious chronic diseases or in their last months of life.

Furthermore, he said, there are limits to how much patients can be expected to hunt for deals.

"Are you going to look for the price of every antibiotic? Every needle? Every syringe?" Roberts asked. "At some point, it becomes absurd."

A second opinion

It made sense to Vikki Brueggeman to ask how much a doctor visit would cost before she recently went to UW Health.

The 53-year-old from Stoughton, who had breast cancer 13 years ago, discovered another lump. She saw a doctor through her health maintenance organization. He performed a mammogram, which was inconclusive, and said Brueggeman should wait three months before considering other action.

She wanted a second opinion but knew she might have to pay for it herself. She called UW Health, which told her the visit would cost $200 to $700.

"It's hard to make intelligent decisions with such broad price ranges," Brueggeman said.

The visit ended up costing $340. An MRI scan, billed separately, found the lump to be a harmless fibroid.

Foxman, from the town of Middleton, appealed Dean's $942 charge for her ultrasound. Dean said she could pay the $510 she was quoted over the phone.

A fitness and nutrition consultant, Foxman had to pay for the ultrasound herself because she elected not to pay the $250-a-month maternity rider on her high-deductible health plan.

She figured she would break even or save money by paying out-of-pocket for the birth. Due in February, she plans to deliver at home with help from the Madison Birth Center.

Foxman was surprised it was so difficult to get a price for the ultrasound.

"They should be able to tell you how much routine things are going to cost," she said. "An ultrasound is pretty routine."

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